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Perspective

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Patient Referrals: Bridging the Gap in a Critical Student-Run Free Clinic Resource

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Abstract

Background: Patients seeking care at student-run free clinics tend to have complex medical histories and require access to a variety of resources and specialties. Student-run free clinics, as a result, often will collaborate with other organizations, health systems, and interprofessional healthcare workers to provide patients with a wide range of services to meet those needs. Unfortunately, student-run free clinics across disciplines continue to experience difficulties with providing patients with access to referrals comparable to what might be available in traditional fee-for-service settings. Some particular challenges include maintaining longitudinal partnerships with local health systems, ensuring patient follow-up, and holistically meeting a wide spectrum of patient concerns. Each student-run free clinic is unique in its clinical focus and operations, resulting in differing capacities to meet the various needs of their communities.
Purpose: To describe generalizable strategies for overcoming challenges related to providing patients with access to referral services based on interprofessional discussions from the "Bridging the Gap" session at the Society of Student-Run Free Clinics 2023 Annual Meeting.
Summary: Three main areas to improve referral services were identified: 1) utilizing internal referrals and incorporating data-tracking, 2) developing a community-centered database of healthcare resources and social services, and 3) addressing specific patient needs, including transportation to and from appointments. Future evaluation of these interventions should be completed to determine the efficacy and impact on patient outcomes.

Introduction

Student-run free clinics (SRFC) have a unique role in promoting community health by providing critically necessary healthcare services for vulnerable and medically underserved individuals. Prior studies evaluating the outcomes of SRFCs found that these clinics can help reduce hospital admission and emergency department visit rates.[1,2] They are also crucial in addressing social determinants of health in their respective communities.[3,4]

There is considerable diversity among SRFCs.[5,6] Each SRFC's model varies based on community-specific needs and demographics, types of medical services offered, and financial and institutional-level support, among other factors.[7] Yet, many SRFCs across the United States (US) have come to offer multidisciplinary care that potentially includes, but is not limited to medical, dentistry, optometry, physical therapy, occupational therapy, social work, and other allied health

Table 1. Proposed recommendations and interventions from the "Bridging the Gap" collaborative session

Recommendation	Suggested Interventions for SRFCs
Prioritizing in-house referrals	• In-house referrals for specialty services • Internal database of community providers • Same-day scheduling
Developing a centralized database	• Dashboard of local and state-wide resources for patient referrals • Data tracking system to manage external referrals (e.g., Unite Us)
Addressing transportation needs	• List of available transportation resources • Uber Health partnership • Patient navigation to assist with transportation • Loval government advocacy efforts

SRFCs: student-run free clinics.

disciplines. A number of SRFCs also provide prescriptions and referrals for other services within and outside their respective clinics. Referral management, however, remains a significant challenge for SRFCs, in part due to the complexity of patients' needs and the scope and consistency of available resources.[7-9] This includes not only scheduling referrals, but also ensuring completion and follow-up of said referrals. Inability to access or complete these follow-ups in a timely manner can further limit SRFC resources and adversely impact SRFCs' relationships with healthcare systems and community entities.

Methods

Given these barriers, key issues regarding referral services within the SRFC setting and avenues to streamline the referral process were discussed at the Society of Student-Run Free Clinics 2023 Annual Meeting's "Bridging the Gap" session. This functioned as an interprofessional session during which health professional students from various backgrounds and institutions formed groups to problem-solve topics of continued interest to SRFCs. Our group was comprised of ten medical students and physician assistant students who have served on SRFC leadership for the past one to two years from three US-based, community-centered multidisciplinary SRFCs located in the Midwest and South.

Initially, five unique topics were brainstormed, with the list then finalized to three main topics following brief presentation and discussion of each idea. Based on shared community experiences across clinic sites, the group reached consensus that in-house referrals, centralized databases, and transportation needs represented some of the most pressing issues with which SRFCs contend. Specifically, these aforementioned topics were chosen based on group members' accounts of how these issues created barriers to accessing healthcare for the patients seen at their local SRFCs. Additional topics that were brainstormed, such as the integration of electronic health records as opposed to paper-based charts within SRFC systems, were ultimately excluded due to feasibility and the varying financial and technological constraints of individual SRFCs which might otherwise limit generalizability of recommendations. All ideas were documented on a large, shared poster during the "Bridging the Gap" session and later transferred to an electronic file for continued collaboration. The authors represented in this article reflect student group members and a faculty physician advisor with extensive experience in SRFC operations who confirmed interest in further developing ideas for resource-sharing purposes. Collectively, the authors drew from individual experiences in quality improvement, public health practice, and research in clinical sciences to reach these recommendations. This article seeks to highlight recommendations that emerged from the "Bridging the Gap" discussions to help SRFCs more effectively navigate referrals (Table 1).

Prioritizing In-House Referrals

Rationale

SRFC services are impacted by the scope of practice of supervising faculty members. As a result, even if certain evaluations or procedures fall within the scope of a given specialty, individual

experience or practice limitations may reduce the breadth of conditions patients can seek care for in the SRFC setting.[10,11] However, multi-specialty services offered by SRFCs provide workarounds to these hurdles; as a result, patients may gain essential access to more specialized evaluations and treatments that previously were out of reach.[12,13]

Potential Interventions

Utilizing in-house referrals when possible can be an important way to facilitate continuity of care.[13] An example of this approach, employed by various SRFCs across the country, is described in the literature by the University of California, San Diego (UCSD) Student-Run Free Clinic Project.[14] Through intentional local partnerships over the years, the UCSD Student-Run Free Clinic Project has grown to house monthly specialty clinics such as diabetes care, dermatology, cardiology, and dental care at specific clinic locations.

In-house referrals can provide patients with benefits of familiarity with and established trust in their care locations, facilities, and staff as they seek help for potentially anxiety-inducing or vulnerable concerns. For the SRFC team, in-house referrals may also justify acquisition of more advanced patient care equipment, oversight of the services available, and provide a means for more consistent, collaborative follow-up. Furthermore, this process which centralizes care at one location versus dispersing across several sites and already has been adopted in various clinical settings through interprofessional practice models can mitigate administrative burdens for both patients and SRFC volunteers alike.[15] Notably, the feasibility of coordinating in-house referrals may be contingent upon access to and availability of healthcare resources in the region, including whether an SRFC is affiliated with or located in close proximity to a larger-scale hospital system.[7]

SRFCs may also consider developing and maintaining an internal master list of community healthcare professionals across different specialties and service areas.[16] This strategy is modeled after coalition-building practices often employed by federally-qualified health centers to connect medically-underserved patients to multiple care specialties.[17] It is anticipated that any community healthcare providers identified will have been vetted by the SRFC beforehand and have committed to seeing a certain number of SRFC patients a year. These partnerships enable SRFCs to readily schedule referrals to these known provider sites and meet a greater breadth of patient needs without the anticipated hurdles of securing additional faculty and resource commitments.

Furthermore, many SRFC patients experience logistical and structural barriers, including, but not limited to, transportation, financial, and housing instability.[18] These inequities contribute to care gaps that can make accessing services provided at SRFCs difficult to obtain. As such, strategies such as same-day scheduling of appointments based on patient preferences, or grouping of related health services (e.g., psychiatry and mental health counseling/therapy) when possible can reduce the severity of these challenges, expedite care, and contribute to better follow-up among patients by creating a coordinated "one-stop shop" approach in the clinical setting.[19] Finally, SRFCs may consider reserving a limited number of appointments per session, especially at each specialty clinic, for urgent referral consultations to help ensure that patients are seen by the necessary SRFC teams in a timely manner.

Limitations

While SRFCs can serve as a growing space for integrating more services based on capacity and community needs, not all specialties, especially those involving specialized technology and resources can be embedded in the SFRC infrastructure. As such, SRFCs may consider exploring opportunities with institutionally-affiliated and external hospital systems when possible to bridge these care gaps, to connect patients to subsidized specialty services that fall outside the scope of the SRFC, and to meaningfully supplement resource pools available to community members. Also, attempts at centralizing resources as previously noted should be carefully balanced with potential adverse impacts on overall SRFC accessibility. Moreover, SRFCs should investigate how to optimize scope of practice and community reach within their existing service lines before investing resources in creating new services that may ultimately result in redundancies.

Another recurring challenge experienced by

SFRCs is retaining longitudinal community physician involvement. Some physicians may already be seeing underinsured and uninsured patients in their practices, and they may elect to contribute to SRFCs by seeing a limited number of SRFC patients.[20,21] This model can make ensuring consistency in access difficult though as the SRFC does not retain oversight over this resource. It also may pose difficulties for patients to travel to these community physician offices, especially if patients already are facing transportation challenges and the sites are not geographically proximate to their respective SRFCs. Additionally, SRFCs would need to ensure the referral process minimizes potential for patient perceptions of discrimination or otherwise not belonging when seeking out these external clinical services.

Developing a Centralized Database

Rationale

Detailed knowledge of a community's needs, its existing resources, and any barriers to expanding or optimizing such resources is essential in establishing a system toward developing an appropriate intervention.[19] This is particularly critical for SRFCs in their pursuit of developing various referral services and connecting patients with resources that would best address their needs and circumstances.[22,23] Additionally, it is expected that a SRFC maintains a functional understanding of how best to operationalize these resources, which can help facilitate trust between patients and the clinic.

Potential Interventions

Creating a comprehensive dashboard of local and state referrals in partnership with trusted community leaders, faith-based organizations, and nonprofits is one potential method to address this need.[8,24] The database should be inclusive of health and social services, including physical and occupational therapy, housing and rental assistance, county indigent care programs, food distributions, substance use and mental health services, dental and vision care, community center programs, and emergency preparedness resources.[25] Consolidation and coordination of these resources have been shown to promote synergies between medical care and community health, with the understanding that patients' healthcare needs and priorities are multifactorial.[19] The dashboard should ideally be easily accessible for both providers and clinic volunteers when making referrals and housed under a user interface that requires minimal training to use proficiently.

For external referrals, establishing a system of data tracking, either through patients' electronic medical record or another online platform, can help confirm if referrals are successfully completed and identify procedural barriers.[26] For instance, a specialist's office may require a referring office, such as the SRFC, to complete paperwork and send patient records in advance before a patient can be scheduled. If an SRFC is unaware of this and anticipates instead that the specialist's office will schedule the patient and assist afterwards with completion of new patient paperwork and obtaining of patient records, delays in initiation of care and loss of confidence in the SRFC system may result. This challenge could likely be overcome by having a SRFC student team specially dedicated to referral management, which would provide a means for closed-loop referral tracking for various social services.[8,27] One resource several clinics have previously reported success with using to coordinate referrals is Unite Us, a digital referral management system that allows organizations to complete screenings and connect individuals to other local agencies.[28] Through Unite Us, the SRFC is able to refer patients to participating community organizations, track referral completion, and receive real-time updates on patients' health and care plan.[28] Community organizations need to register with the Unite Us service in order to be visible to other members, so while the listing may not be all-encompassing, it can provide a standardized way for SRFCs to longitudinally monitor referral data and outcomes.

Limitations

There are some potential barriers that may limit the feasibility of creating a centralized, referral care service database. First, potential funding and staffing restrictions may hinder or altogether prohibit the design and implementation of the referral database. This would also be a compounding limitation in ensuring all resource

listings are kept up-to-date and that participating SRFCs and organizations meet regularly to foster a strong relationship in co-caring for common patients. Additionally, due to variation in SRFC's health record systems and electronic capabilities, there may be restricted utility in the use of a digital database; in these instances, extra care will be required to ensure compatibility between different documentation methods. Lastly, a sustainable program will need to be implemented to provide students with sufficient training, ideally in partnership with other organizations included in the database, to competently navigate the database, identify the resources pertinent to the specific needs of each patient, and to fluidly onboard new student leadership whilst preserving institutional memory.

Addressing Transportation Needs

Rationale

Many patients relying on SRFC services have multiple social determinants of health concerns, including but not limited to food insecurity, housing instability, and concerns for domestic violence.[16,27,29] One particularly noteworthy challenge is difficulties in transportation which drastically impact patient ability to access and follow-up with referrals, especially when any resources they are connected with are located somewhere other than the SRFC. This is particularly salient for the populations SRFCs typically serve who are more likely to be socioeconomically marginalized, medically underserved, and uninsured.[3,30-32]

Potential Interventions

To effectively address these issues, SRFCs may consider developing a comprehensive list of transportation resources that are likely available in most communities. Options may include government-sponsored programs such as Dial-a-Ride, insurance-backed programs such as Medi-Car, privately-owned, non-emergency medical transportation service, and individual rideshare programs. Within the published SFRC literature, the Robert R. Frank Student-Run Free Clinic located in Detroit, Michigan described using Uber Health to provide safe transportation, resulting in a significant reduction of no-show rates among their patient population.[33] Transportation information could be compiled and distributed as pamphlets or handouts in an SRFC waiting area, and a well-trained SRFC patient navigation team can help patients pursue eligible transportation resources based on financial need. An example of effective patient navigation can be seen with the Case Western Reserve University SRFC, which reported including patient advocates or case managers to assist patients with accessing essential social support services, such as housing and food resources.[34]

Student volunteers and leaders within SRFCs can also engage in multidisciplinary public health and advocacy efforts to address the upstream factors that may affect issues such as transportation access for patients. Investigating the practicality and sustainability of adopting ride-share resources including, but not limited to, Uber Health in areas with limited public transit is one potential option to assist patients with attending their appointments. Another option is working with local organizations and government leadership to provide complimentary bus passes, to expand existing public transit networks, and/or to implement one or more new public transit access points in close proximity to the SRFC. A clinic may even consider pushing for local support to charter a bus or incentivizing non-emergency patient transportation companies within service areas known to have concentrations of current or potential SRFC patients in order to provide community members with safe transit to and from the SRFC.

Limitations

Transportation barriers are among the most significant hurdles to care faced by SRFC patients. Many of these individuals possess limited English proficiency which can make reaching out for any assistance a daunting task. Patients may also have inconsistent phone access which precludes them entirely from reaching out for help, lack familiarity with surroundings especially if traveling significant distances to be seen at an SRFC, and experience housing insecurity which may make it difficult for individuals to leave a certain geographical area to seek care. Given these intersecting social determinants of health, it is important for SRFCs to work collaboratively with social workers and case managers to screen and

identify patients who would most benefit from transportation-related support, among other vital community resources.

Conclusions

Providing patients with access to intra-clinic and external referrals is an integral part of SRFC operations. These processes can pose distinctive challenges with regards to scheduling, arranging for services, and encouraging patient follow-up. Holistic strategies that include developing a robust internal referral system, establishing a user-friendly database of local resources, and ensuring individual patient resource needs such as transportation are addressed prior to referral appointments can assist SRFCs with managing a functional service network and providing longitudinal patient care. Future quality improvement and research directions should assess the impacts and sustainability of these proposed interventions on patient health outcomes, clinic operation metrics, and community partnerships.

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Disclosures

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